

REFERENCE TITLE: health; budget reconciliation

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008

HB 2869

Introduced by
Representative Weiers J (with permission of committee on Rules)

AN ACT

AMENDING SECTIONS 36-2901.03 AND 36-2912, ARIZONA REVISED STATUTES; AMENDING
TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION
36-2912.04; RELATING TO HEALTH BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-2901.03, Arizona Revised Statutes, is amended to
3 read:

4 36-2901.03. Federal poverty program; eligibility

5 A. The administration shall adopt rules for a streamlined eligibility
6 determination process for any person who applies to be an eligible person as
7 defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The
8 administration shall adopt these rules in accordance with state and federal
9 requirements and the section 1115 waiver.

10 B. The administration must base eligibility on an adjusted gross
11 income that does not exceed one hundred per cent of the federal poverty
12 guidelines.

13 C. For persons who the administration determines are eligible pursuant
14 to this section, the date of eligibility is the first day of the month of
15 application.

16 D. Except as provided in ~~subsection~~ SUBSECTIONS E AND F of this
17 section, the administration shall determine an eligible person's continued
18 eligibility ~~on an annual basis~~ AT LEAST ANNUALLY.

19 E. Every six months the administration shall determine the continued
20 eligibility of any adult who is at least twenty-one years of age and who is
21 subject to redetermination of eligibility for temporary assistance for needy
22 families cash benefits by the department. Acute care redeterminations
23 pursuant to this subsection shall begin on ~~the effective date of this~~
24 ~~amendment to this section~~ SEPTEMBER 19, 2007 and shall occur simultaneously
25 with redeterminations of eligibility for temporary assistance for needy
26 families cash benefits.

27 F. EVERY SIX MONTHS THE ADMINISTRATION SHALL DETERMINE THE CONTINUED
28 ELIGIBILITY OF ANY ADULT WITHOUT DEPENDENT CHILDREN WHO IS ALL OF THE
29 FOLLOWING:

30 1. AT LEAST TWENTY-ONE YEARS OF AGE.

31 2. DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901.01.

32 3. NOT OTHERWISE ELIGIBLE AS A MANDATORY OR OPTIONALLY ELIGIBLE MEMBER
33 PURSUANT TO TITLE XIX OF THE SOCIAL SECURITY ACT AS AUTHORIZED BY THE STATE
34 PLAN.

35 Sec. 2. Section 36-2912, Arizona Revised Statutes, is amended to read:

36 36-2912. Healthcare group coverage; program requirements for
37 small businesses and public employers; related
38 requirements; definitions

39 A. The administration shall administer a healthcare group program to
40 allow willing contractors to deliver health care services to persons defined
41 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),
42 (d) and (e). ~~In the absence of a willing contractor~~ IN COUNTIES WITH A
43 POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS, the administration may
44 contract directly with any health care provider or entity. The

1 administration may enter into a contract with another entity to provide
2 administrative functions for the healthcare group program.

3 B. Employers with one eligible employee or up to an average of fifty
4 eligible employees under section 36-2901, paragraph 6, subdivision (d):

5 1. May contract with the administration to be the exclusive health
6 benefit plan if the employer has five or fewer eligible employees and enrolls
7 one hundred per cent of these employees into the health benefit plan.

8 2. May contract with the administration for coverage available
9 pursuant to this section if the employer has six or more eligible employees
10 and enrolls eighty per cent of these employees into the healthcare group
11 program.

12 3. Shall have a minimum of one and a maximum of fifty eligible
13 employees at the effective date of their first contract with the
14 administration.

15 C. The administration shall not enroll an employer group in healthcare
16 group sooner than one hundred eighty days after the date that the employer's
17 health insurance coverage under an accountable health plan is discontinued.
18 Enrollment in healthcare group is effective on the first day of the month
19 after the one hundred eighty day period. This subsection does not apply to
20 an employer group if the employer's accountable health plan discontinues
21 offering the health plan of which the employer is a member.

22 D. Employees with proof of other existing health care coverage who
23 elect not to participate in the healthcare group program shall not be
24 considered when determining the percentage of enrollment requirements under
25 subsection B of this section if either:

26 1. Group health coverage is provided through a spouse, parent or
27 legal guardian, or insured through individual insurance or another employer.

28 2. Medical assistance is provided by a government subsidized health
29 care program.

30 3. Medical assistance is provided pursuant to section 36-2982,
31 subsection I.

32 E. An employer shall not offer coverage made available pursuant to
33 this section to persons defined as eligible pursuant to section 36-2901,
34 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally
35 designated plan.

36 F. An employee or dependent defined as eligible pursuant to section
37 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in
38 healthcare group on a voluntary basis only.

39 G. Notwithstanding subsection B, paragraph 2 of this section, the
40 administration shall adopt rules to allow a business that offers healthcare
41 group coverage pursuant to this section to continue coverage if it expands
42 its employment to include more than fifty employees.

43 H. The administration shall provide eligible employees with disclosure
44 information about the health benefit plan.

1 I. The director shall:

2 1. Require that any contractor that provides covered services to
3 persons defined as eligible pursuant to section 36-2901, paragraph 6,
4 subdivision (a) provide separate audited reports on the assets, liabilities
5 and financial status of any corporate activity involving providing coverage
6 pursuant to this section to persons defined as eligible pursuant to section
7 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

8 2. Beginning on July 1, 2005, require that a contractor, the
9 administration or an accountable health plan negotiate reimbursement rates
10 and not use the administration's reimbursement rates established pursuant to
11 section 36-2903.01, subsection H, as a default reimbursement rate if a
12 contract does not exist between a contractor and a provider.

13 3. Use monies from the healthcare group fund established by section
14 36-2912.01 for the administration's costs of operating the healthcare group
15 program.

16 4. Ensure that the contractors are required to meet contract terms as
17 are necessary in the judgment of the director to ensure adequate performance
18 by the contractor. Contract provisions shall include, at a minimum, the
19 maintenance of deposits, performance bonds, financial reserves or other
20 financial security. The director may waive requirements for the posting of
21 bonds or security for contractors that have posted other security, equal to
22 or greater than that required for the healthcare group program, with the
23 administration or the department of insurance for the performance of health
24 service contracts if funds would be available to the administration from the
25 other security on the contractor's default. In waiving, or approving waivers
26 of, any requirements established pursuant to this section, the director shall
27 ensure that the administration has taken into account all the obligations to
28 which a contractor's security is associated. The director may also adopt
29 rules that provide for the withholding or forfeiture of payments to be made
30 to a contractor for the failure of the contractor to comply with provisions
31 of its contract or with provisions of adopted rules.

32 5. Adopt rules.

33 6. Provide reinsurance to the contractors for clean claims based on
34 thresholds established by the administration. For the purposes of this
35 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

36 J. With respect to services provided by contractors to persons defined
37 as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c),
38 (d) or (e), a contractor is the payor of last resort and has the same lien or
39 subrogation rights as those held by health care services organizations
40 licensed pursuant to title 20, chapter 4, article 9.

41 K. The administration shall offer a health benefit plan on a
42 guaranteed issuance basis to small employers as required by this section.
43 All small employers qualify for this guaranteed offer of coverage. The
44 administration shall provide a health benefit plan to each small employer
45 without regard to health status-related factors if the small employer agrees

1 to make the premium payments and to satisfy any other reasonable provisions
 2 of the plan and contract. The administration shall offer to all small
 3 employers the available health benefit plan and shall accept any small
 4 employer that applies and meets the eligibility requirements. In addition to
 5 the requirements prescribed in this section, for any offering of any health
 6 benefit plan to a small employer, as part of the administration's
 7 solicitation and sales materials, the administration shall make a reasonable
 8 disclosure to the employer of the availability of the information described
 9 in this subsection and, on request of the employer, shall provide that
 10 information to the employer. The administration shall provide information
 11 concerning the following:

- 12 1. Provisions of coverage relating to the following, if applicable:
- 13 (a) The administration's right to establish premiums and to change
- 14 premium rates and the factors that may affect changes in premium rates.
- 15 (b) Renewability of coverage.
- 16 (c) Any preexisting condition exclusion.
- 17 (d) The geographic areas served by the contractor.
- 18 2. The benefits and premiums available under all health benefit plans
- 19 for which the employer is qualified.

20 L. The administration shall describe the information required by
 21 subsection K of this section in language that is understandable by the
 22 average small employer and with a level of detail that is sufficient to
 23 reasonably inform a small employer of the employer's rights and obligations
 24 under the health benefit plan. This requirement is satisfied if the
 25 administration provides the following information:

- 26 1. An outline of coverage that describes the benefits in summary form.
- 27 2. The rate or rating schedule that applies to the product,
- 28 preexisting condition exclusion or affiliation period.
- 29 3. The minimum employer contribution and group participation rules
- 30 that apply to any particular type of coverage.
- 31 4. In the case of a network plan, a map or listing of the areas
- 32 served.

33 M. A contractor is not required to disclose any information that is
 34 proprietary and protected trade secret information under applicable law.

35 N. At least sixty days before the date of expiration of a health
 36 benefit plan, the administration shall provide a written notice to the
 37 employer of the terms for renewal of the plan.

38 O. The administration ~~may~~ **SHALL** increase or decrease premiums based on
 39 actuarial reviews **BY AN INDEPENDENT ACTUARY** of the projected and actual costs
 40 of providing health care benefits to eligible members. Before changing
 41 premiums, the administration must give sixty days' written notice to the
 42 employer. ~~The administration may cap the amount of the change.~~ **FOR EACH**
 43 **CONTRACT PERIOD THE ADMINISTRATION SHALL SET PREMIUMS THAT IN THE AGGREGATE**
 44 **COVER PROJECTED MEDICAL AND ADMINISTRATIVE COSTS FOR THAT CONTRACT PERIOD AND**

1 THAT ARE DETERMINED PURSUANT TO GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND
2 PRACTICES BY AN INDEPENDENT ACTUARY.

3 P. The administration ~~may~~ SHALL consider age, sex, ~~income~~ GROUP SIZE,
4 GEOGRAPHIC AREA and community rating when it establishes premiums for the
5 healthcare group program.

6 Q. Except as provided in subsection R of this section, a health
7 benefit plan may not deny, limit or condition the coverage or benefits based
8 on a person's health status-related factors or a lack of evidence of
9 insurability. A HEALTH BENEFIT PLAN SHALL NOT PROVIDE OR OFFER ANY SERVICE,
10 BENEFIT OR COVERAGE THAT IS NOT A PART OF THE HEALTH BENEFIT PLAN CONTRACT.

11 R. A health benefit plan shall not exclude coverage for preexisting
12 conditions, except that:

13 1. A health benefit plan may exclude coverage for preexisting
14 conditions for a period of not more than twelve months or, in the case of a
15 late enrollee, eighteen months. The exclusion of coverage does not apply to
16 services that are furnished to newborns who were otherwise covered from the
17 time of their birth or to persons who satisfy the portability requirements
18 under this section.

19 2. The contractor shall reduce the period of any applicable
20 preexisting condition exclusion by the aggregate of the periods of creditable
21 coverage that apply to the individual.

22 S. The contractor shall calculate creditable coverage according to the
23 following:

24 1. The contractor shall give an individual credit for each portion of
25 each month the individual was covered by creditable coverage.

26 2. The contractor shall not count a period of creditable coverage for
27 an individual enrolled in a health benefit plan if after the period of
28 coverage and before the enrollment date there were sixty-three consecutive
29 days during which the individual was not covered under any creditable
30 coverage.

31 3. The contractor shall give credit in the calculation of creditable
32 coverage for any period that an individual is in a waiting period for any
33 health coverage.

34 T. The contractor shall not count a period of creditable coverage with
35 respect to enrollment of an individual if, after the most recent period of
36 creditable coverage and before the enrollment date, sixty-three consecutive
37 days lapse during all of which the individual was not covered under any
38 creditable coverage. The contractor shall not include in the determination
39 of the period of continuous coverage described in this section any period
40 that an individual is in a waiting period for health insurance coverage
41 offered by a health care insurer or is in a waiting period for benefits under
42 a health benefit plan offered by a contractor. In determining the extent to
43 which an individual has satisfied any portion of any applicable preexisting
44 condition period the contractor shall count a period of creditable coverage
45 without regard to the specific benefits covered during that period. A

1 contractor shall not impose any preexisting condition exclusion in the case
2 of an individual who is covered under creditable coverage thirty-one days
3 after the individual's date of birth. A contractor shall not impose any
4 preexisting condition exclusion in the case of a child who is adopted or
5 placed for adoption before age eighteen and who is covered under creditable
6 coverage thirty-one days after the adoption or placement for adoption.

7 U. The written certification provided by the administration must
8 include:

9 1. The period of creditable coverage of the individual under the
10 contractor and any applicable coverage under a COBRA continuation provision.

11 2. Any applicable waiting period or affiliation period imposed on an
12 individual for any coverage under the health plan.

13 V. The administration shall issue and accept a written certification
14 of the period of creditable coverage of the individual that contains at least
15 the following information:

16 1. The date that the certificate is issued.

17 2. The name of the individual or dependent for whom the certificate
18 applies and any other information that is necessary to allow the issuer
19 providing the coverage specified in the certificate to identify the
20 individual, including the individual's identification number under the policy
21 and the name of the policyholder if the certificate is for or includes a
22 dependent.

23 3. The name, address and telephone number of the issuer providing the
24 certificate.

25 4. The telephone number to call for further information regarding the
26 certificate.

27 5. One of the following:

28 (a) A statement that the individual has at least eighteen months of
29 creditable coverage. For THE purposes of this subdivision, "eighteen months"
30 means five hundred forty-six days.

31 (b) Both the date that the individual first sought coverage, as
32 evidenced by a substantially complete application, and the date that
33 creditable coverage began.

34 6. The date creditable coverage ended, unless the certificate
35 indicates that creditable coverage is continuing from the date of the
36 certificate.

37 W. The administration shall provide any certification pursuant to this
38 section within thirty days after the event that triggered the issuance of the
39 certification. Periods of creditable coverage for an individual are
40 established by presentation of the certifications in this section.

41 X. The healthcare group program shall comply with all applicable
42 federal requirements.

43 Y. Healthcare group may pay a commission to an insurance producer. To
44 receive a commission, the producer must certify that to the best of the
45 producer's knowledge the employer group has not had insurance in the one

1 hundred eighty days before applying to healthcare group. For the purposes of
 2 this subsection, "commission" means a one time payment on the initial
 3 enrollment of an employer.

4 Z. On or before June 15 and November 15 of each year, the director
 5 shall submit a report to the joint legislative budget committee regarding the
 6 number and type of businesses participating in healthcare group and that
 7 includes updated information on healthcare group marketing activities. The
 8 director, within thirty days of implementation, shall notify the joint
 9 legislative budget committee of any changes in healthcare group benefits or
 10 cost sharing arrangements.

11 AA. THE ADMINISTRATION SHALL SUBMIT THE FOLLOWING TO THE JOINT
 12 LEGISLATIVE BUDGET COMMITTEE:

13 1. QUARTERLY REPORTS REGARDING THE FINANCIAL CONDITION OF THE
 14 HEALTHCARE GROUP PROGRAM. THE REPORTS SHALL INCLUDE THE NUMBER OF PERSONS
 15 AND EMPLOYER GROUPS ENROLLED IN THE PROGRAM AND MEDICAL LOSS INFORMATION AND
 16 PROJECTIONS.

17 2. AN ANNUAL FINANCIAL AUDIT.

18 3. AN ANNUAL WRITTEN STATEMENT BY A MEMBER OF THE AMERICAN ACADEMY OF
 19 ACTUARIES CERTIFYING THAT, BASED ON AN EXAMINATION BY THE INDIVIDUAL,
 20 INCLUDING A REVIEW OF THE APPROPRIATE RECORDS AND OF THE ACTUARIAL
 21 ASSUMPTIONS AND METHODS USED BY THE INDEPENDENT ACTUARY IN ESTABLISHING BASE
 22 PREMIUM RATES AND PREMIUM RATES FOR HEALTH BENEFITS PLANS:

23 (a) THE HEALTH BENEFIT PLAN IS IN COMPLIANCE WITH THE APPLICABLE
 24 PROVISIONS OF THIS SECTION.

25 (b) THE RATING METHODS ARE ACTUARIALLY SOUND.

26 ~~AA.~~ BB. For the purposes of this section:

27 1. "Accountable health plan" has the same meaning prescribed in
 28 section 20-2301.

29 2. "COBRA continuation provision" means:

30 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
 31 vaccines, of the internal revenue code of 1986.

32 (b) Title I, subtitle B, part 6, except section 609, of the employee
 33 retirement income security act of 1974.

34 (c) Title XXII of the public health service act.

35 (d) Any similar provision of the law of this state or any other state.

36 3. "Creditable coverage" means coverage solely for an individual,
 37 other than limited benefits coverage, under any of the following:

38 (a) An employee welfare benefit plan that provides medical care to
 39 employees or the employees' dependents directly or through insurance,
 40 reimbursement or otherwise pursuant to the employee retirement income
 41 security act of 1974.

42 (b) A church plan as defined in the employee retirement income
 43 security act of 1974.

44 (c) A health benefits plan, as defined in section 20-2301, issued by a
 45 health plan.

- 1 (d) Part A or part B of title XVIII of the social security act.
2 (e) Title XIX of the social security act, other than coverage
3 consisting solely of benefits under section 1928.
4 (f) Title 10, chapter 55 of the United States Code.
5 (g) A medical care program of the Indian health service or of a tribal
6 organization.
7 (h) A health benefits risk pool operated by any state of the United
8 States.
9 (i) A health plan offered pursuant to title 5, chapter 89 of the
10 United States Code.
11 (j) A public health plan as defined by federal law.
12 (k) A health benefit plan pursuant to section 5(e) of the peace corps
13 act (22 United States Code section 2504(e)).
14 (l) A policy or contract, including short-term limited duration
15 insurance, issued on an individual basis by an insurer, a health care
16 services organization, a hospital service corporation, a medical service
17 corporation or a hospital, medical, dental and optometric service corporation
18 or made available to persons defined as eligible under section 36-2901,
19 paragraph 6, subdivisions (b), (c), (d) and (e).
20 (m) A policy or contract issued by a health care insurer or the
21 administration to a member of a bona fide association.
22 4. "Eligible employee" means a person who is one of the following:
23 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
24 (b), (c), (d) and (e).
25 (b) A person who works for an employer for a minimum of twenty hours
26 per week or who is self-employed for at least twenty hours per week.
27 (c) An employee who elects coverage pursuant to section 36-2982,
28 subsection I. The restriction prohibiting employees employed by public
29 agencies prescribed in section 36-2982, subsection I does not apply to this
30 subdivision.
31 (d) A person who meets all of the eligibility requirements, who is
32 eligible for a federal health coverage tax credit pursuant to section 35 of
33 the internal revenue code of 1986 and who applies for health care coverage
34 through the healthcare group program. The requirement that a person be
35 employed with a small business that elects healthcare group coverage does not
36 apply to this eligibility group.
37 5. "Genetic information" means information about genes, gene products
38 and inherited characteristics that may derive from the individual or a family
39 member, including information regarding carrier status and information
40 derived from laboratory tests that identify mutations in specific genes or
41 chromosomes, physical medical examinations, family histories and direct
42 ~~analysis~~ ANALYSES of genes or chromosomes.
43 6. "Health benefit plan" means coverage offered by the administration
44 for the healthcare group program pursuant to this section.

1 7. "Health status-related factor" means any factor in relation to the
2 health of the individual or a dependent of the individual enrolled or to be
3 enrolled in a health plan including:

- 4 (a) Health status.
- 5 (b) Medical condition, including physical and mental illness.
- 6 (c) Claims experience.
- 7 (d) Receipt of health care.
- 8 (e) Medical history.
- 9 (f) Genetic information.
- 10 (g) Evidence of insurability, including conditions arising out of acts
11 of domestic violence as defined in section 20-448.
- 12 (h) The existence of a physical or mental disability.

13 8. "Hospital" means a health care institution licensed as a hospital
14 pursuant to chapter 4, article 2 of this title.

15 9. "Late enrollee" means an employee or dependent who requests
16 enrollment in a health benefit plan after the initial enrollment period that
17 is provided under the terms of the health benefit plan if the initial
18 enrollment period is at least thirty-one days. Coverage for a late enrollee
19 begins on the date the person becomes a dependent if a request for enrollment
20 is received within thirty-one days after the person becomes a dependent. An
21 employee or dependent shall not be considered a late enrollee if:

- 22 (a) The person:
 - 23 (i) At the time of the initial enrollment period was covered under a
24 public or private health insurance policy or any other health benefit plan.
 - 25 (ii) Lost coverage under a public or private health insurance policy
26 or any other health benefit plan due to the employee's termination of
27 employment or eligibility, the reduction in the number of hours of
28 employment, the termination of the other plan's coverage, the death of the
29 spouse, legal separation or divorce or the termination of employer
30 contributions toward the coverage.

31 (iii) Requests enrollment within thirty-one days after the termination
32 of creditable coverage that is provided under a COBRA continuation provision.

33 (iv) Requests enrollment within thirty-one days after the date of
34 marriage.

35 (b) The person is employed by an employer that offers multiple health
36 benefit plans and the person elects a different plan during an open
37 enrollment period.

38 (c) The person becomes a dependent of an eligible person through
39 marriage, birth, adoption or placement for adoption and requests enrollment
40 no later than thirty-one days after becoming a dependent.

41 10. "Preexisting condition" means a condition, regardless of the cause
42 of the condition, for which medical advice, diagnosis, care or treatment was
43 recommended or received within not more than six months before the date of
44 the enrollment of the individual under a health benefit plan issued by a
45 contractor. Preexisting condition does not include a genetic condition in

1 the absence of a diagnosis of the condition related to the genetic
2 information.

3 11. "Preexisting condition limitation" or "preexisting condition
4 exclusion" means a limitation or exclusion of benefits for a preexisting
5 condition under a health benefit plan offered by a contractor.

6 12. "Small employer" means an employer who employs at least one but not
7 more than fifty eligible employees on a typical business day during any one
8 calendar year.

9 13. "Waiting period" means the period that must pass before a potential
10 participant or eligible employee in a health benefit plan offered by a health
11 plan is eligible to be covered for benefits as determined by the individual's
12 employer.

13 Sec. 3. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
14 amended by adding section 36-2912.04, to read:

15 36-2912.04. Medical loss subsidies; required information

16 THE ADMINISTRATION SHALL ESTABLISH UTILIZATION MANAGEMENT CONTROL
17 STANDARDS FOR PARTICIPATING CONTRACTORS THAT MEET NATIONALLY RECOGNIZED
18 STANDARDS FOR MANAGED CARE UTILIZATION. CONTRACTORS THAT DO NOT MEET THESE
19 STANDARDS ARE NOT ELIGIBLE FOR STOP-LOSS COVERAGE FOR MEDICAL COSTS IN EXCESS
20 OF THESE STANDARDS.

21 Sec. 4. Healthcare group; temporary enrollment freeze

22 Notwithstanding section 36-2912, Arizona Revised Statutes, as amended
23 by this act, beginning August 1, 2008 and ending on July 31, 2011, healthcare
24 group shall not enroll any additional employer groups defined as eligible
25 pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e),
26 Arizona Revised Statutes.

27 Sec. 5. County transfers; fiscal year 2008-2009

28 Notwithstanding any other law, in fiscal year 2008-2009, counties with
29 a population of two million or more persons shall transfer \$17,497,300 and
30 counties with a population of more than eight hundred thousand persons but
31 less than two million persons shall transfer \$4,854,200 to the Arizona health
32 care cost containment system administration for deposit in the budget
33 neutrality compliance fund established by section 36-2928, Arizona Revised
34 Statutes.

35 Sec. 6. AHCCCS; disproportionate share payments

36 Disproportionate share payments for fiscal year 2008-2009 made pursuant
37 to section 36-2903.01, subsection P, Arizona Revised Statutes, include:

38 1. \$89,877,700 for a qualifying nonstate operated public hospital.
39 The Maricopa county special health care district shall provide a certified
40 public expense form for the amount of qualifying disproportionate share
41 hospital expenditures made on behalf of this state to the administration on
42 or before June 1, 2009. The administration shall assist the district in
43 determining the amount of qualifying disproportionate share hospital
44 expenditures. Once the administration files a claim with the federal
45 government and receives federal funds participation based on the amount

certified by the Maricopa county special health care district, if the certification is equal to or greater than \$89,877,700, the administration shall distribute \$4,202,300 to the Maricopa county special health care district and deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than \$89,877,700, and the administration determines that the revised amount is correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives, shall distribute \$4,202,300 to the Maricopa county special health care district and shall deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than \$89,877,700 and the administration determines that the revised amount is not correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the total amount of the federal funds participation in the state general fund.

2. \$28,614,300 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of the state to the administration on or before March 31, 2009. The administration shall assist the Arizona state hospital in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Arizona state hospital, the administration shall distribute the entire amount of federal financial participation to the state general fund. If the certification provided is for an amount less than \$28,614,300, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall distribute the entire amount of federal financial participation to the state general fund. The certified public expense form provided by the Arizona state hospital shall contain both the total amount of qualifying disproportionate share hospital expenditures and the amount limited by section 1923(g) of the social security act.

3. \$26,147,700 for private qualifying disproportionate share hospitals.

Sec. 7. County acute care contribution; fiscal year 2008-2009

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2008-2009 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1. Apache	\$ 268,800
2. Cochise	\$ 2,214,800
3. Coconino	\$ 742,900
4. Gila	\$ 1,413,200

1	5. Graham	\$ 536,200
2	6. Greenlee	\$ 190,700
3	7. La Paz	\$ 212,100
4	8. Maricopa	\$21,552,700
5	9. Mohave	\$ 1,237,700
6	10. Navajo	\$ 310,800
7	11. Pima	\$14,951,800
8	12. Pinal	\$ 2,715,600
9	13. Santa Cruz	\$ 482,800
10	14. Yavapai	\$ 1,427,800
11	15. Yuma	\$ 1,325,100

12 B. If a county does not provide funding as specified in subsection A
 13 of this section, the state treasurer shall subtract the amount owed by the
 14 county to the Arizona health care cost containment system fund and the
 15 long-term care system fund established by section 36-2913, Arizona Revised
 16 Statutes, from any payments required to be made by the state treasurer to
 17 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona
 18 Revised Statutes, plus interest on that amount pursuant to section 44-1201,
 19 Arizona Revised Statutes, retroactive to the first day the funding was due.
 20 If the monies the state treasurer withholds are insufficient to meet that
 21 county's funding requirements as specified in subsection A of this section,
 22 the state treasurer shall withhold from any other monies payable to that
 23 county from whatever state funding source is available an amount necessary to
 24 fulfill that county's requirement. The state treasurer shall not withhold
 25 distributions from the highway user revenue fund pursuant to title 28,
 26 chapter 18, article 2, Arizona Revised Statutes.

27 C. Payment of an amount equal to one-twelfth of the total amount
 28 determined pursuant to subsection A of this section shall be made to the
 29 state treasurer on or before the fifth day of each month. On request from
 30 the director of the Arizona health care cost containment system
 31 administration, the state treasurer shall require that up to three months'
 32 payments be made in advance, if necessary.

33 D. The state treasurer shall deposit the amounts paid pursuant to
 34 subsection C of this section and amounts withheld pursuant to subsection B of
 35 this section in the Arizona health care cost containment system fund and the
 36 long-term care system fund established by section 36-2913, Arizona Revised
 37 Statutes.

38 E. If payments made pursuant to subsection C of this section exceed
 39 the amount required to meet the costs incurred by the Arizona health care
 40 cost containment system for the hospitalization and medical care of those
 41 persons defined as an eligible person pursuant to section 36-2901, paragraph
 42 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of
 43 the Arizona health care cost containment system administration may instruct
 44 the state treasurer either to reduce remaining payments to be paid pursuant
 45 to this section by a specified amount or to provide to the counties specified

1 amounts from the Arizona health care cost containment system fund and the
2 long-term care system fund.

3 F. It is the intent of the legislature that the Maricopa county
4 contribution pursuant to subsection A of this section be reduced in each
5 subsequent year according to the changes in the GDP price deflator. For the
6 purposes of this subsection, "GDP price deflator" has the same meaning
7 prescribed in section 41-563, Arizona Revised Statutes.

8 Sec. 8. ALTCS; county contributions

9 Notwithstanding section 11-292, Arizona Revised Statutes, county
10 contributions for the Arizona long-term care system for fiscal year 2008-2009
11 are as follows:

12	1. Apache	\$ 631,900
13	2. Cochise	\$ 5,673,800
14	3. Coconino	\$ 1,896,000
15	4. Gila	\$ 2,352,400
16	5. Graham	\$ 1,216,100
17	6. Greenlee	\$ 118,900
18	7. La Paz	\$ 890,300
19	8. Maricopa	\$161,590,300
20	9. Mohave	\$ 8,441,300
21	10. Navajo	\$ 2,614,000
22	11. Pima	\$ 41,487,700
23	12. Pinal	\$ 12,972,300
24	13. Santa Cruz	\$ 1,939,800
25	14. Yavapai	\$ 9,260,600
26	15. Yuma	\$ 6,902,400

27 Sec. 9. Hospitalization and medical care contribution; fiscal
28 year 2008-2009

29 A. Notwithstanding any other law, for fiscal year 2008-2009, beginning
30 with the second monthly distribution of transaction privilege tax revenues,
31 the state treasurer shall withhold the following amounts from state
32 transaction privilege tax revenues otherwise distributable, after any amounts
33 withheld for the county long-term care contribution or the county
34 administration contribution pursuant to section 11-292, subsection P, Arizona
35 Revised Statutes, for deposit in the Arizona health care cost containment
36 system fund established by section 36-2913, Arizona Revised Statutes, for the
37 provision of hospitalization and medical care:

38	1. Apache	\$ 87,300
39	2. Cochise	\$ 162,700
40	3. Coconino	\$ 160,500
41	4. Gila	\$ 65,900
42	5. Graham	\$ 46,800
43	6. Greenlee	\$ 12,000
44	7. La Paz	\$ 24,900
45	8. Mohave	\$ 187,400

1	9. Navajo	\$ 122,800
2	10. Pima	\$1,115,900
3	11. Pinal	\$ 218,300
4	12. Santa Cruz	\$ 51,600
5	13. Yavapai	\$ 206,200
6	14. Yuma	\$ 183,900

7 B. If a county does not provide funding as specified in subsection A
8 of this section, the state treasurer shall subtract the amount owed by the
9 county to the Arizona health care cost containment system fund from any
10 payments required to be made by the state treasurer to that county pursuant
11 to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus
12 interest on that amount pursuant to section 44-1201, Arizona Revised
13 Statutes, retroactive to the first day the funding was due. If the monies
14 the state treasurer withholds are insufficient to meet that county's funding
15 requirement as specified in subsection A of this section, the state treasurer
16 shall withhold from any other monies payable to that county from whatever
17 state funding source is available an amount necessary to fulfill that
18 county's requirement. The state treasurer shall not withhold distributions
19 from the highway user revenue fund pursuant to title 28, chapter 18, article
20 2, Arizona Revised Statutes.

21 C. Payment of an amount equal to one-twelfth of the total monies
22 prescribed pursuant to subsection A of this section shall be made to the
23 state treasurer on or before the fifth day of each month. On request from
24 the director of the Arizona health care cost containment system
25 administration, the state treasurer shall require that up to three months'
26 payments be made in advance, if necessary.

27 D. The state treasurer shall deposit the monies paid pursuant to
28 subsection C of this section in the Arizona health care cost containment
29 system fund established by section 36-2913, Arizona Revised Statutes.

30 E. In fiscal year 2008-2009, the sum of \$2,646,200 withheld pursuant
31 to subsection A or B of this section, as applicable, is allocated for the
32 county acute care contribution for the provision of hospitalization and
33 medical care services administered by the Arizona health care cost
34 containment system administration.

35 F. County contributions made pursuant to subsection A of this section
36 are excluded from the county expenditure limitations.

37 Sec. 10. Child care eligibility levels; report

38 Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal
39 year 2008-2009, the department of economic security may reduce maximum income
40 eligibility levels for child care assistance in order to manage within
41 appropriated and available monies. The department shall notify the joint
42 legislative budget committee of any change in maximum income eligibility
43 levels for child care within fifteen days after implementing that change.

1 Sec. 11. Competency restoration treatment; county and city
2 reimbursement; fiscal year 2008-2009; deposit; tax
3 withholding

4 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if the
5 state pays the costs of a defendant's inpatient competency restoration
6 treatment pursuant to section 13-4512, Arizona Revised Statutes, for counties
7 with a population of eight hundred thousand or more persons and for all
8 cities, the city or county shall reimburse the department of health services
9 for eighty-six per cent of these costs for fiscal year 2008-2009.

10 B. The department shall deposit the reimbursements, pursuant to
11 sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state
12 hospital fund established by section 36-545.08, Arizona Revised Statutes.

13 C. Each city and county shall make the reimbursements for these costs
14 as specified in subsection A of this section within thirty days after a
15 request by the department. If the city or county does not make the
16 reimbursement, the superintendent of the Arizona state hospital shall notify
17 the state treasurer of the amount owed and the treasurer shall withhold the
18 amount, including any additional interest as provided in section 42-1123,
19 Arizona Revised Statutes, from any transaction privilege tax distributions to
20 the city or county. The treasurer shall deposit the withholdings, pursuant
21 to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state
22 hospital fund established by section 36-545.08, Arizona Revised Statutes.

23 Sec. 12. Proposition 204 administration; county expenditure
24 limitation

25 County contributions for the administrative costs of implementing
26 sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made
27 pursuant to section 11-292, subsection O, Arizona Revised Statutes, are
28 excluded from the county expenditure limitations.

29 Sec. 13. Health insurance premiums; department of
30 administration

31 For fiscal year 2008-2009, the department of administration shall not
32 implement a differentiated health insurance premium based on the integrated
33 or nonintegrated status of a health insurance provider available through the
34 state employee health insurance program beginning October 1, 2008.

35 Sec. 14. Health insurance benefits; legislative approval;
36 retroactivity

37 A. Notwithstanding any other law, the department of administration
38 shall not make changes to the benefit design or eligibility of the health
39 insurance benefit program in fiscal year 2008-2009 unless those changes have
40 been approved by the legislature.

41 B. This section is effective retroactively to from and after December
42 31, 2007.

43 Sec. 15. Eligibility; benefit levels; enrollment; agencies

44 Notwithstanding any other law, the Arizona health care cost containment
45 system, the department of economic security and the department of health

1 services may change the eligibility or benefit level of programs, or freeze
2 enrollment in programs, in order to comply with the agencywide lump sum
3 reduction for their agency in the fiscal year 2008-2009 general appropriation
4 act. Changes made to the eligibility or benefit level of programs, or an
5 enrollment freeze, shall not conflict with federal law or be in violation of
6 the provisions of article IV, part 1, section 1, Constitution of Arizona.